

WILLOWS PEDIATRIC GROUP

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I hereby authorize Willows Pediatric Group to release my medical health records including a copy of my complete and entire mental health record, all records for my care and treatment, including psychiatric and drug information, and information regarding HIV/AIDs status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, x-ray reports.

I understand that no psychotherapy notes may be disclosed by my signing this authorization and that a separate authorization would be required for the release of psychotherapy notes.

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the Code of Federal Regulations, which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

Records being requested consist of: (Examples: "Entire Record", "Records from 2012-Present" "Concussion 2016")

Please check reason for transfer: Family Relocation
 Transfer to Adult Physician
 Change of Insurance (Which Insurance? _____)
 Other (please explain) _____

MEDICAL RECORDS TO BE SENT TO:

Office/Name: _____

Fax Number (if immunizations are to be sent ahead.): _____

Address: _____

City/State/Zip: _____

	(Date of Birth)	(Signature *)
Patient Name(s) _____	_____	_____
_____	_____	_____
_____	_____	_____

(*PLEASE NOTE: As part of the HIPAA regulations, any child 13 yrs or older must sign for themselves.)

Requests take up to 30 days to complete but are often completed sooner. Requests are completed in the order that they are received. If you would like your child's immunization records sent ahead of the full records, please supply the fax number and this will be done within a few days of receiving your request.

Please note that only **ONE COPY OF RECORDS** may be released at no cost and further copies would incur a cost. If you have any questions about your request, please call (203) 319-3939, ext. 1246.

Record Release forms can be sent by mail, fax OR email:
Willows Pediatrics
Attn: Records Department
1563 Post Road East
Westport, CT 06880
Fax: (203)319-3966 / Email: clinical@willowspediatrics.com

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of the provider listed above.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

Signature: _____
Print Name: _____
Relationship to Patient: _____
Date: _____

This authorization expires: _____

If a representative signs, describe the representative's authority to act on behalf of the patient:

PLEASE NOTE: *We must ask you to show ID if you are picking up your records. If someone other than the parent/responsible party picks up records they will be required to present written permission to do so from the parent/responsible party.*

PLEASE SEE THE FOLLOWING PAGE OF THIS FORM FOR SPECIAL DISCLOSURE INFORMATION REGARDING MENTAL HEALTH, DRUG AND/OR ALCOHOL ABUSE, AND HIV-RELATED INFORMATION.

WILLOWS PEDIATRIC GROUP
1563 POST ROAD EAST
WESTPORT, CT 06880
203-319-3939

TO THE RECIPIENT OF THESE MATERIALS:

HIV/AIDS INFORMATION: In the event that any of the disclosed information includes HIV/AIDS information, this is protected under state law as follows:

“This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.” Any oral disclosure shall be accompanied or followed by the above notice. See Connecticut General Statute section 19a-585

PSYCHIATRIC COMMUNICATIONS: If the released material contains confidential psychiatric communication, as designated in C.G.S sections 52-146d through 52-146i, inclusive, please note the following:

“The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes” A copy of the consent form setting forth any limitations shall accompany the disclosure.

DRUG & ALCOHOL TREATMENT: No person, hospital, treatment facility or department of health may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and/or alcohol abuse that would be in violation of federal or state law. In the event that the records contain information regarding drug and/or alcohol abuse treatment, please note the following legal requirements and prohibitions:

“This information has been disclosed to you from records protected by federal and state confidentiality rules (42 C.F.R Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.” See Connecticut General Statute section 17a-688.